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be effective on the first day of the calendar quarter following one-hundred and eighty days after the end of the cost reporting period.

- (2) After the end of the fiscal year in which the NF began participation in the medical assistance program, the rates for the second fiscal year and subsequent fiscal years shall be set using the NF's cost report filed under rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid and the provisions of rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code. If the NF did not file a cost report for the full calendar year preceding the fiscal year, ODJFS shall use the following principles to set the rate for the second fiscal year:
- (a) If the NF was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the NF began participation in the medical assistance program October second of that calendar year or later, the rate shall be determined under paragraph (A)(1) of this rule.
- (b) If the NF was required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the NF began participation in the medical assistance program October first of that calendar year or earlier, the rate shall be determined under rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code, except as follows:
- (i) The inflation rate used to inflate the NF's desk reviewed, actual, allowable per diem cost shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined for each applicable cost center for the fiscal year. Capital costs are not inflated.
- (ii) The NF's actual CPCMU is determined by dividing the NF's desk-reviewed, actual, allowable, per diem direct care costs from the partial calendar year cost report by the NF's actual case-mix score(s) for the reporting quarter or quarters that ended during the cost report period. Until the facility submits assessment information that qualifies for use in calculating an actual case-mix score(s), ODJFS shall use the median CPCMU for the facility as prescribed by paragraph (A)(1)(a)(i) of this rule.

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(c) If the NF was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the NF began participation in the medical assistance program after the end of the calendar year, the rate shall be determined under paragraph (A)(1) of this rule.

(B) The ODJFS shall determine rates for a NF provider that changes provider agreements as set forth under rule 5101:3-3-51.6 of the Administrative Code within the existing building in the following manner:

(1) For the fiscal year in which change of provider agreement occurs, the new provider's initial rate shall be the same rate and method of calculation as the previous provider, except as follows:

(a) The previous providers rate must have been calculated using costs reported for a time period no older than the calendar year preceding the current fiscal year. If the costs used to calculate the previous provider's rate do not relate to the calendar year preceding the current fiscal year or a three month period during the current fiscal year, the new provider's rate will be the peer group median rate calculated as follows:

(i) The direct care median rate will be calculated as determined under paragraph (A)(1)(a)(i) of this rule.

(ii) The protected median rate will be calculated as determined under paragraph (A)(1)(b)(i) of this rule.

(iii) The indirect median rate shall be the median indirect care cost reported for the calendar year preceding the fiscal year in which the rate will be paid for the applicable peer group adjusted for inflation calculated in accordance with ~~5101:3-3-83~~ 5101:3-3-50 of the Administrative Code.

(iv) The capital median rate will be calculated as determined in accordance with ~~5101:3-3-84~~ 5101:3-3-51 of the Administrative Code.

(b) The new provider may request a change in its capital rate under rule 5101:3-3-24 of the Administrative Code.

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- (c) After the new provider files its three-month cost report under paragraph (E)(1)(d) of rule 5101:3-3-20 of the Administrative Code, the rate shall be determined under rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code using the costs reported on the three-month cost report, except as follows:
- (i) The inflation rate used to inflate the new provider's desk-reviewed, actual, allowable per diem cost reported on the three-month cost report shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined for each applicable cost center for that fiscal year. Capital costs are not inflated.
 - (ii) The new provider's actual CPCMU shall be calculated by dividing the actual, allowable, per diem direct care costs reported on the three-month cost report by the new provider's actual case-mix score(s) for the reporting quarter or quarters that ends during the cost report period. Until the new provider submits assessment information that qualifies for use in calculating an actual case-mix score(s), ODJFS shall use the median CPCMU for the facility as prescribed by paragraph (A)(1)(a)(i) of this rule.
 - (iii) If the three month cost report is filed after the ninety day due date and this report results in a lower rate, the rate shall be effective on the first day of the calendar quarter following one-hundred and eighty days after the end of the cost reporting period.
 - (iv) The rate calculated based upon the three-month cost report shall be effective starting the first day of the calendar quarter that begins more than ninety days after ODJFS receives the cost report, except those reports under paragraph (B)(1)(c)(iii) of this rule.
- (2) After the end of the fiscal year in which the change of provider agreement occurred, the rates for the second fiscal year and subsequent fiscal years shall be set using the new provider's cost report filed under rule 5101:3-3-20 of the Administrative Code for the full calendar year preceding the fiscal year in which the rate will be paid and the provisions of rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code.
- (a) If the new provider was required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the

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calendar year preceding the fiscal year in which the rate will be paid because the change of provider agreement occurred October first of that calendar year or earlier, the rate shall be determined under rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code except as follows:

- (i) The inflation rate used to inflate the new provider's desk-reviewed, actual, allowable per diem cost reported on the calendar year ending cost report shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined for each applicable cost center for that fiscal year. Capital costs are not inflated.
- (ii) The CPCMU shall be calculated by dividing the actual, allowable, per diem direct care costs reported on the partial calendar year ending cost report by the actual case mix score(s) for the reporting quarter or quarters that ended during the cost report period. Until the new provider submits assessment information that qualifies for use in calculating an actual case-mix score(s), ODJFS shall use the median CPCMU for the facility as prescribed by paragraph (A)(1)(a)(i) of this rule.
- (b) If the new provider was assigned the previous providers rate pursuant to paragraph (B)(1)(a) of this rule and the new provider was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the change of provider agreement occurred October second of that calendar year or later or after the end of the calendar year, the rate shall be the same as the rate that was in effect at the end of the preceding fiscal year adjusted by the inflation rates and limited to ceilings as determined for the fiscal year under rules 5101:3-3-44, 5101:3-3-49, and 5101:3-3-50 of the Administrative Code. The rate shall be adjusted as provided in paragraphs (B)(1)(a) and (B)(1)(b) of this rule.
- (c) If the new providers rate in the first fiscal year was the peer group median rate, the second fiscal year will also be the peer group median rate, as established for the second fiscal year, until a cost report for the new provider is received pursuant to paragraph (B)(2) of this rule.
- (3) The provisions set forth under paragraph (B) of this rule do not apply to NFs which are new to the medical assistance program as defined under paragraph (A) of this rule, including NFs which receive a new license based upon the

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relocation of beds from existing NFs in operation immediately before the opening of the new NF. The rates for these NFs are calculated under paragraph (A) of this rule, as replacement facilities.

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Certification

09/02/2003

Date

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Rule Amplifies: RC 5111.01, 5111.02,
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Nursing facilities (NFs): nonreimbursable costs.

(J) Expenses associated with lawsuits filed against the Ohio department of ~~human services~~job and family services (ODJFS) which are not upheld by the courts.

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(K) Cost of meals sold to visitors or public (i.e., meals on wheels).

(L) Cost of supplies or services sold to nonfacility residents or public.

(M) Cost of operating a gift shop.

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**Intermediate care facilities for the mentally retarded
(ICFs-MR): method for establishing the total prospective rate.**

- (A) The method for establishing the total prospective rate for ICFs-MR is the combination of allowable per diems established for direct care, other protected care, indirect care and capital costs as set forth in rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83 and ~~5101:3-3-84.2~~ 5101:3-3-84.2 of the Administrative Code. The Ohio department of ~~human services (ODHS)~~ job and family services (ODJFS) shall not reduce the rates calculated pursuant to these rules on the basis that the facility charges a lower rate to any resident who is not eligible for medicaid.
- (B) After ~~ODHS~~ ODJFS receives the cost reports for a cost reporting period, ~~ODHS~~ ODJFS shall perform a desk review of each cost report. Based on the desk review, ~~ODHS~~ ODJFS shall make a preliminary determination whether the costs are allowable. No later than July first of each year, ~~ODHS~~ ODJFS shall notify each ICF-MR if any of its costs are preliminarily determined not to be allowable and of its rate calculation and shall explain the reasons for the results. ~~ODHS~~ ODJFS shall allow the ICF-MR to verify the calculation and, if necessary, submit additional information.
- (C) ~~ODHS~~ ODJFS shall calculate and establish new rates beginning July first of each fiscal year as set forth in rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83 and ~~5101:3-3-84.2~~ 5101:3-3-84.2 of the Administrative Code. Effective on the first day of each calendar quarter, the direct care per diem of the rate will be adjusted to reflect new assessment information submitted pursuant to rule 5101:3-3-75 of the Administrative Code.